Federal Bills Raise Cap on Medicare-Funded Residency Positions and Modify Graduate Medical Education Policies

Kristin Schleiter, JD, LLM
Lauren Johnson, EdD, MNA

The federal government is the largest source of graduate medical education (GME) funding in the United States. The varied mechanisms by which federal funds flow to GME programs are complex, with both mandatory and discretionary funding and multiple avenues through which GME programs serving rural and underserved areas and populations can receive grant funding to build and maintain residency programs.

Congress recently took steps to support several programs supporting GME funding by fixing technical issues that left some rural programs with an inadvertently low cap, expanding eligibility for rural training track funding, and adding 1000 new Medicare-funded positions for the first time since 1997. This article discusses the underlying bill that prompted these changes and a proposed rule in which the Centers for Medicare & Medicaid Services (CMS) proffered details about how it may implement them. It will also highlight GME provisions of the American Rescue Plan of 2021, the COVID-19 relief package passed in March 2021.

Consolidated Appropriations Act of 2021 and COVID-19 Relief Bill

In December 2020, the Fiscal Year 2021 omnibus spending bill, the Consolidated Appropriations Act of 2021 (CAA), was signed into law.[1] The spending package, which funds federal agencies through September 30, 2021, included a $900 billion COVID-19 stimulus package.

The COVID-19 stimulus provides $22.7 billion for the Higher Education Emergency Relief Fund, directing $20.2 billion for public and private, non-profit institutions of higher education, including osteopathic medical schools, to be distributed by a formula considering head count and full-time equivalent (FTE) enrollment. The stimulus allows for $25.4 billion to support testing and contract tracing to monitor COVID-19, with targeted funds to improve efforts in high-risk and underserved populations. Health care professionals will also receive $3 billion in reimbursements for health care expenses and financial losses in 2020 attributable to the COVID-19 pandemic.

The spending portions of the CAA extended certain GME training programs through fiscal year (FY) 2023, including the Teaching Health Center GME program, the National Health Service Corps, community health centers, and the Children's Hospital GME program. Many programs critical to GME, including the Children's Hospital GME program, received increased funding from last year's levels.

In addition, the CAA contained 3 provisions affecting Medicare direct GME and indirect medical education (IME) payments to teaching hospitals. Section 126 of the CAA makes available 1000 new Medicare-funded GME positions (but no more than 200 new positions each FY), to be distributed beginning in FY 2023, with priority given to hospitals in 4 statutorily specified categories. Section 127 of the CAA makes statutory changes relating to the determination of both urban and rural hospitals' FTE limit for direct GME and IME payment purposes with regard to residents training in an accredited rural training track, and the 3-year rolling average used to calculate payments for these hospitals. Section 131 of the CAA makes statutory changes to the determination of direct GME per resident amounts (PRAs) and direct GME and IME FTE resident limits of hospitals that hosted residents for a short duration. Each of these provisions will be discussed in turn (BOX).

1000 New CMS-Funded Residency Positions

The spending measure added 1000 new Medicare-funded residency positions for the first time since 1997. The framework resembles the recurrent Resident Physician Shortage Reduction Act, which has been reintroduced in the 117th Congress and calls for an additional 14 000 positions to be funded.

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BOX Graduate Medical Education (GME) Provisions in Consolidated Appropriations Act of 2021

- Section 126–Makes available 1000 new Medicare-funded GME positions.
- Section 127–Makes statutory changes relating to the determination of both an urban and a rural hospital's FTE limit for direct GME and IME payment purposes regarding residents training in an accredited rural training track.
- Section 131–Makes statutory changes to the determination of direct GME PRAs and direct GME and IME (FTE) resident limits of hospitals that hosted residents for a short duration.

Abbreviations: FTE, full-time equivalent; IME, indirect medical education; PRAs, per resident amounts.

Until now, increases for urban teaching hospitals with resident caps set at the time of the Balanced Budget Act of 1997 have only occurred from policy changes directing the redistribution of existing residency slots. The new provision lifts the cap on Medicare-funded positions by creating 1000 new direct GME (DGME) and IME slots beginning October 1, 2022. Starting in FY 2023, CMS will award no more than 200 slots per year until the 1000 spots are filled.

CMS will engage in a separate round of applications for the new slots, with applications to be submitted January 31 of a fiscal year for positions, effective July 1 of the following fiscal year.[2] The completed application must be submitted to CMS using an online application under development. A link to the online application system and instructions will be made available on the CMS DGME website when the final rule is published.[3]

The new law establishes parameters for the new slots, including what kind of hospitals qualify. At least 10% of the slots must be awarded to hospitals in each of the following categories:

- Category 1–Hospitals in a rural area or treated as being in a rural area for payment;
- Category 2–Hospitals training residents above the DGME and IME caps;
- Category 3–Hospitals in a state with new medical schools, additional locations, or branch campuses; or
- Category 4–Hospitals serving Health Professional Shortage Areas (HPSAs).

There are also rules for receipt of the slots—for example, hospitals must already have a resident level greater than the otherwise applicable limit and must agree to increase the number of residency positions by the same number as the additional slots. There are also payment rules for receipt of the slots.

On May 10, 2021, CMS published Proposed Rules[4] that outline and provide additional detail about CMS's proposed application process for the new slots, including proposed ranking criteria for distribution within the 4 categories above.

CMS has proposed limiting the increase in residency positions made available to no more than 1.0 FTE for each hospital (not each program) each year. The Proposed Rules would also require all applicant hospitals to attest that they meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards).

In the Proposed Rules, CMS recommends prioritization within certain categories to address health inequities. For example, within Category 4, CMS suggests prioritizing applications from hospitals from population HPSAs that serve such specific designated underserved populations as low-income populations, Medicaid-eligible populations, Native American populations, homeless populations, and migrant farmworker populations. Hospitals that do not serve HPSAs won't be categorically excluded but would have the lowest priority.

CMS has also proposed an alternative prioritization process through which higher priority would be given to hospitals that qualify in 1 or more of the 4 categories above. Hospitals that qualify under all 4 categories would receive the highest priority. CMS is seeking comment on both proposed approaches.

CMS has proposed that the application deadline for the additional positions available for a fiscal year be January 31 of the prior fiscal year. According to the Proposed Rule, for FY 2023 the application deadline for the first year's slots would be January 31, 2022.

In determining which hospitals will receive new residency positions, CMS must consider the likelihood of the hospital filling the positions made available within the first 5 training years after the increase would go into account. In the Proposed Rules, CMS proposes that the hospital could show this likelihood in its application by demonstrating that it does not have sufficient room under its current FTE resident cap(s) to accommodate a planned new program or expansion of an existing program, and demonstrating that it intends to use the additional FTEs to establish a new residency program or expand an existing residency program. The Proposed Rules provide details about how CMS expects hospitals to make this demonstration.

The new law requires CMS to report back at least twice on distribution of the new positions and where the physicians who filled those slots went on to

TABLE
Hospital Categorization for Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

	Category A Hospitals	Category B Hospitals
Definition	Those with a PRA established based on less than 1.0 FTE in any cost reporting period before October 1, 1997	Those with a PRA established based on training no more than 3.0 FTEs in any cost reporting period before October 1, 1997
PRA reset threshold	Once CMS determines that the relevant hospital trains at least 1.0 FTE in a cost reporting period between December 27, 2020, and December 26, 2025	Once CMS determines the hospitals trains more than 3.0 FTEs in a cost reporting period between December 27, 2020, and December 26, 2025

Abbreviations: GME, graduate medical education; FTE, full-time equivalent; IME, indirect medical education; PRA, per resident amounts; CMS, Centers for Medicare & Medicaid Services.

practice. CMS accepted public comment on the Proposed Rules and will publish Final Rules this fall.

Fix for Artificially Low Cap

The spending bill eliminated the CMS penalty imposed on certain community hospitals that have hosted "rotator" residents for brief periods and allows those hospitals to establish new residency programs without limitations on the number of residency slots. The new law allows hospitals to host a certain number of medical residents for short-term rotations without triggering the permanent FTE resident cap or per resident amounts.

The provision is structured to delay the establishment of the PRA, DGME cap, and if applicable, IME cap, or provide a "restart" opportunity for hospitals that had their PRAs and Medicare GME caps inadvertently set because of a small number of residency rotations.

The section sets a new threshold amount level below which CMS is not permitted to calculate hospital-specific amounts in the future. It also provides an opportunity for more reasonable PRA amounts and Medicare GME caps for certain hospitals for future payment periods, if the hospitals have already had those amounts set at low levels. In its Proposed Rule, CMS has proposed redetermining the PRA for residents either in an approved program that is "new" for Medicare IME and direct GME purposes or in an existing approved program. CMS has also proposed categorizing hospitals based on the current cap to determine when a hospital's cap-building period will start or be reset (TABLE).

The Proposed Rule specifies that CMS will reset the FTE resident caps based on the relevant triggering threshold for approved programs that are "new" for Medicare IME and DGME purposes or an existing program.

CMS plans to issue instructions to Medicare Administrative Contractors and hospitals to provide for an orderly process of request and review for the purpose of receiving replacement PRAs.

Changes to Rural Training Track Rules

The spending bill eased rural training track (RTT) requirements to provide greater opportunity for Medicare funding for permanent direct GME and IME cap increases for hospitals that develop rural-urban partnerships to address the physician workforce needs of rural areas. Medicare rules include a RTT provision incentivizing urban hospitals to partner with hospitals and other settings in rural areas to cross-train residents. However, several challenges were identified:

- Only the urban hospital and not the rural hospital in an urban-rural partnership was allowed to receive additional cap slots based on the time the residents in the RTT trained at the relevant hospital;
- No cap adjustment was allowed when an urban hospital added rural locations to an existing RTT;
- The residency program was required to be "separately accredited" with approved residency training tracks in a rural area, which in practice, limited RTTs to family medicine programs; and
- Residents added to a RTT were not exempt from the 3-year rolling average for IME and direct GME.

The CAA addressed these concerns in several ways.

Elimination of Separate Accreditation Requirement

First, the new law removes the requirement that RTTs be separately accredited programs. Instead, CMS has proposed that any ACGME-accredited program may qualify as an RTT if all other requirements are met, such as a requirement that greater than 50% of the

program occur in a rural area. CMS has proposed that this provision go into effect for cost reporting periods beginning on or after October 1, 2022.

The CAA also authorizes both urban and rural hospitals to be eligible for DGME and IME cap increases. According to the Proposed Rule, both rural and urban hospitals with an RTT would be authorized to include in the FTE count, not to exceed the respective hospitals' rural track FTE limitation, the time RTT residents train in the urban and rural hospital, respectively.

Expanded Eligibility for RTT Funding Cap

The CAA also removes previous language stating that hospitals would only be eligible for cap adjustments if the applicable residency program was deemed to be a newly established program. In the future, according to the Proposed Rules, both urban and rural hospitals may receive a rural track FTE limitation each time an RTT is established for the first time, even if the RTT program doesn't meet newness criteria for Medicare payment purposes.

In its Proposed Rule, CMS observes that the authority to adjust the cap of an urban hospital wishing to create additional RTTs after establishing its first RTT was an authority not previously held. Currently, CMS is authorized to adjust the cap only for new urban teaching hospitals and rural hospitals with new programs. According to the Proposed Rule, if an urban hospital with a RTT ("hub") adds an additional RTT ("spoke") to the existing urban core program of the same specialty, both the urban and rural hospital may receive adjustments to their FTE limitation.

CMS expressed its belief in the Proposed Rule that allowing experienced urban "hub" RTTs to branch out and partner with additional rural communities rather than starting from scratch is an efficient means of addressing rural health care workforce shortages.

However, CMS wants to be judicious in its approach. As such, in its Proposed Rule, CMS proposes limiting increases to the urban and rural hospitals' RTT FTE limitations *only* in the instance where additional residents are recruited to add a new rural "spoke" RTT and *not* to allow increases where the urban and rural hospital add FTE residents to an existing "spoke" site. CMS observes, however, that slots are fungible, and as such, urban and rural hospitals with multiple RTT "spokes" may reallocate the number of FTE residents training at each track in order to accommodate increases or decreases in training and funding at such "spokes."

CMS has also proposed allowing an urban hospital with an existing RTT in a specialty to receive an adjustment to its rural track FTE limitation if it starts another RTT in a different specialty. CMS will not consider the RTT in a different specialty an expansion of an existing RTT.

Finally, the Proposed Rules provide that, while the RTT specialty cap is being built, both rural and urban hospitals are eligible for a temporary exemption from the 3-year rolling average rule and the intern and resident-to-bed ratio cap rule. This change mirrors the exemption from these rules for hospitals creating new residency programs and is intended to fix a temporary lag in DGME and IME payments when the RTT specialty cap is being built—a particular challenge to rural hospitals' ability to participate in RTTs. The method for calculating cap assignments and adjustments is outlined in detail in the Proposed Rule.

American Rescue Plan

The American Rescue Plan[5] came on the heels of the $900 billion COVID-19 relief in December 2020 and was signed into law March 11, 2021. The $1.9 trillion package funds health resources to battle the COVID-19 pandemic and provides continued aid to affected Americans, businesses, and state, local, and tribal governments. The legislation was enacted as part of Congress's FY 2021 budget and includes provisions affecting a wide variety of stakeholders. The following highlights some noteworthy provisions relevant to health care and GME.

Of the $9.1 billion in public health workforce support, $7.7 billion is dedicated to establishing, expanding, and sustaining a public health workforce to help respond to the pandemic through awards to state, local, and territorial public health departments. Public health departments may use awarded funds to recruit, hire, and train staff to fulfill a wide variety of functions, such as case investigators, contact tracers, laboratory personnel, and community health workers. Included in this funding are:

- $330 million for teaching health center GME sites, including a $10,000 per resident increase in the per resident amount, and funding for planning and development grants to help community-based programs to achieve accreditation;
- $800 million for the National Health Service Corps, which provides loan forgiveness and scholarships to primary care health clinicians serving in HPSAs; and
- $100 million to support the Medical Reserve Corps, a network of volunteer network of health professionals and others who assist in response to natural and public health disasters.

The American Rescue Plan also provides $3.5 billion in block grants addressing behavioral health disorders and several million more for behavioral health programs and workforce issues. This funding includes $1.5 billion each for mental health and substance use disorder block grants. Funding also includes $100 million for HRSA's Behavioral Health Workforce Education and Training Program[6] to expand access to behavioral health services through focused training for behavioral health professionals, paraprofessionals, and public safety officers. This program aims to increase access to behavioral health services by increasing the supply of behavioral health professionals and improving distribution of a quality behavioral health workforce.

Funding also supports use of mental health services by health care professionals and first responders through funding for training, educational programs, and other initiatives designed to promote mental and behavioral wellness. Some of the provisions mirror the Dr. Lorna Breen Health Care Provider Protection Act,[7] bipartisan legislation to reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals.

Specifically, the law provides:

- $20 million for an education campaign directed at health care personnel and first responders to encourage identification and prevention of behavioral health disorders;
- $80 million in grants to health professional schools, academic medical centers, local government, and other nonprofits for training in evidence-based strategies to decrease behavioral health disorders among health care personnel;
- $30 million in grants for local governments, nonprofits, and health organizations for overdose prevention and harm reduction programs; and
- $100 million to programs addressing community-based and child and adolescent mental health.

While it remains to be seen what additional opportunities for support of GME will arise in the 117th Congress, the developments of the past quarter are a promising start.

References

1. Consolidated Appropriations Act of 2021, Pub. L. 116-120 (2020). www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf. Accessed June 16, 2021.
2. Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program. Federal Register. https://www.federalregister.gov/documents/2021/05/10/2021-08888/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. Accessed June 16, 2021.
3. Centers for Medicare & Medicaid Services. Direct Graduate Medical Education (DGME). www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. Accessed June 16, 2021.
4. Department of Health and Human Services. Centers for Medicare & Medicaid Services. 42 CFR Parts 412, 413, 425, 455, and 495. Federal Register. Vol. 86, No. 88. May 10, 2021. Proposed Rules. www.govinfo.gov/content/pkg/FR-2021-05-10/pdf/2021-08888.pdf. Accessed June 16, 2021.
5. American Rescue Plan Act of 2021, Pub. L. 117-2 (2021). www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf. Accessed June 16, 2021.
6. Health Resources and Services Administration. Behavioral Health Workforce and Training Program for Professionals. www.hrsa.gov/grants/find-funding/hrsa-21-089. Accessed June 16, 2021.
7. Dr. Lorna Breen Health Care Provider Protection Act, S 610, 117th Cong. (2021). www.congress.gov/bill/117th-congress/senate-bill/610. Accessed June 16, 2021.

Kristin Schleiter, JD, LLM, is Vice President, Public Policy and External Affairs, Accreditation Council for Graduate Medical Education (ACGME); and **Lauren Johnson, EdD, MNA,** is Associate Director, Public Policy, ACGME.

Corresponding author: Kristin Schleiter, JD, LLM, Accreditation Council for Graduate Medical Education, kschleiter@acgme.org